

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/10/2021
NAME OF PROVIDER OR SUPPLIER THE WATERS OF SHELBYVILLE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 835 UNION STREET SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies This Rule is not met as evidenced by: Complaint investigation #TN00055605 was completed on 11/9/2021 at The Waters of Shelbyville, LLC. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE